

# MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

## PART I: GENERAL INFORMATION

<b>Type of Requestor:</b> (x) HCP    ( ) IE    ( ) IC		<b>Response Timely Filed?</b> (x) Yes    ( ) No	
Requestor's Name and Address  Texas Imaging & Diagnostic Center 3840 W. NW HWY Ste #400 Dallas TX 75220		MDR Tracking No.: M4-03-7097-01	
		TWCC No.:	
		Injured Employee's Name:	
Respondent's Name and Address                      BOX #: 19  Valiant Ins. Co. c/o Flahive, Ogden & Latson 505 West 12 <sup>th</sup> St. Austin TX 78701		Date of Injury:	
		Employer's Name: Landmark Structures I, LP	
		Insurance Carrier's No.: 2230101255	

## PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
5/17/02	5/17/02	72148 WP-22	\$924.00	\$924.00

## PART III: REQUESTOR'S POSITION SUMMARY

"...The Insurance company has not issued an EOB allowing or denying payment...We submitted this claim back on May 20, 2002, December 18, 2002, April 22, 2003 and May 13, 2003..."

## PART IV: RESPONDENT'S POSITION SUMMARY

"...Carrier requests that the MR-116 of June 10, 2003 be withdrawn...Also, the Carrier has filed a TWCC-21 and TWCC-45 for this file and requests that this dispute be held in abeyance until the commission resolved the other issues..."

## PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

Neither the carrier nor the requestor provided EOB's for date of service 5/17/02.

The local TWCC denied acceptance of the TWCC-21 filed on 5/17/02 by the respondent. On 6/3/02 the notes Indicated the "carrier did not timely dispute the change of doctors approved by TWCC on 5/1/02, Form 45 was filed on 5/17/02." Therefore the TWCC 21 is not an issue.

The requestor submitted convincing evidence of carrier receipt of provider's request for an EOB in accordance with 133.307(e)(2)(B). Respondent did not provide EOB's per Rule 133.307(e)(3)(B).

According to MFG-Radiology/Nuclear Ground Rules I, A,2, whole procedure, MAR includes the technical and professional components. The requestor submitted convincing evidence of the services rendered.

Reimbursement recommended: \$924.00.

**PART VI: DETAIL FINDINGS (If needed)**

Date of Service	CPT Code	Amount in Dispute	Amount Due	Date of Service	CPT Code	Amount in Dispute	Amount Due
5/17/2002	72148WP	\$924.00	\$924.00				
				Total Left Column:			\$924.00
				Total Amount Due:			\$924.00

**PART VII: COMMISSION DECISION AND ORDER**

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to additional reimbursement in the amount of **\$924.00**. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

Ordered by:

	Carol Lawrence	2 /10/ 05
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	Carol Lawrence	2 /10/ 05
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Authorized Signature

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Typed Name

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Date of Order

## PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on \_\_\_\_\_. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

**Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**

## PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: \_\_\_\_\_ Date: \_\_\_\_\_/ 0 5